IN THE UNITED STATES DISTRICT COURT FOR THE MIDDLE DISTRICT OF TENNESSEE NASHVILLE DIVISION

BRIAN MOAT,	
Plaintiff,	
v.)	Case No.: 3:21-cv-00807
THE METROPOLITAN) GOVERNMENT OF) NASHVILLE AND DAVIDSON) COUNTY, TENNESSEE,)	JUDGE TRAUGER JURY DEMAND
Defendants.	
BUSINESS RECORD	S AFFIDAVIT
Comes now Kimberly Jordan an	
1. I am employed by Davies	as a Claims Manage
My job duties include maintaining records for this bus	siness.
2. In my authority with Davies	I have the authority to certify the
attached records for Brian Moat	
 The attached records are true and accurate 	urate copies of all of the records described in
Jesse Harbison Law's request for records sent on Jun	e 23rd, 2022.
4. The attached records were prepared by	y the personnel of Davies
or persons acting under its control, in the ordinary co	ourse of their regularly conducted business at
or near the time of the act, condition or event reported	ed in the records and making the records was
a regular practice.	
5. It is the policy of Davies	that the personnel preparing

these records have knowledge of the information that is recorded in these records, and has a business duty to timely make and maintain true and accurate records.

6. The charge of \$____ for furnishing these copies is reasonable.

BUSINESS RECORDS) CUSTODIAN

COUNTY OF Davidson

Personally appeared before me, the undersigned, a Notary Public, in and for said county and state, the within named Limberty Torcar with whom I am personally acquainted (or upon the basis of satisfactory evidence presented to me), who, after being duly sworn, made oath that he/she executed the foregoing for the purposes therein contained.

WITNESS my hand and official seal this _____ day of _______, 2022.

STATE
OF
TENNESSEE
NOTARY
PUBLIC
SON COUNTY

My Commission Expires:

March 3, 2026

aren June



Form - 201 Injury On Duty (IOD) Report

Date:	2-13-19
Time in;	935 Am
Time Out:_	11:00 Am
Front Desk	Initials: CP

		Ilme Our: 17 - 90 /17-
Facility: Metro IOD Clinic		Front Desk Initials: <u>CP</u>
Moat, Brian J.	HAMB A.	
Employer: Metro IOD Clinic-ONSITE ONLY	HOME #:	
SSN: DOB: 06/13/1968		
Case Date: 12/12/2019		
	JURY: (IN	ITIAL / RECHECK (PLEASE CIRCLE)
,		may reduce (manda pinota)
TREATING PHYSICIAN: Dr. Rebecca	Smith HOW WAS AUTHORIZATION OBT	TAINED?_ASC
. acuse		_
DESCRIPTION OF INJURY: WM Par a	disc herniation with radio	Whothy weareness
ASSESSMENT/DIAGNOSIS://	(/) (/
ASSESSIMENT/DIAGNOSIS		-
Is condition claimed and compatible to	o be work related? BYes D No	1
Known pre-existing or other conditions	contributing? ☐ Yes ☐ No	
TREATMENT RENDERED: 12 Xam.	referral	x. £
TARRIO ATIONIC CONCERNIA OF CO		
MEDICATIONS: (prescribed)		
/	RETURN TO WORK OUTLINE	
RETURN TO REGULAR DUTY	UPPER EXTREMITY	BACK
		Sitting job only
DISCHARGED FROM CARE		Alternate sit/stand
	No lift/push/pull over lbs.	May stand/walkup to hrs/day
SENT HOME (UNABLE TO WORK)	No repetitive/heavy gripping	No repetitive sloop/bend/twist
		May stoop/bend/twisttimes/hour
ADMITTED TO:	No repetitive/outstretched arm use	Weight limitlbs.
LIMITED DUTY	LOWER EXTREMITY	OTHER
IF LIMITED DUTY NOT AVAILABLE MUST BE	Sitting job with foot/leg elevated	Keep dressing clean/dry
BE OPF WORK UNTIL NEXT VISIT	Alternate sit/stand, may walk short distances	
	No squaffing or kneeling	No use of hazardous machinery
	No running/jumping	Must wear brace as directed
	No climbing stairs/ladders	Medications may cause drowsiness
4 J-MVII		Do not takę at work.
Additional notes;		
	7	
DATE TO RETURN TO REGULAR DUTY:	□ NO DATE: //_	TIME
	If you need to resche	TIME:
REFERRAL TO SPECIALTY: OF THE SOME		(ASC to make referral)
REFERRAL TO PHYSICAL THERAPY:		ASC to make referral)
REFERRAL TO DIAGNOSTIC TESTING	,	(ASC to make referral)
I understand this report and agreemenge	receipt of a copy:	00
19, 11/1/	12 . 7 . 12	i of h. le
Patient: asese22/24/d000007 D00000		3061644PElera (1004#E140221/)
COMPLETED COPY WAS PAXED TO ASC AT 6	15-360-5692 FROM THE METRO IOD CLINIC. R	ETAIN'COPY IN EMPLOYEE'S FILE.



Injury On Duty (IOD) Report

Facility: HOWILL ALKEIN CLINIC M	ledical Record #:	Time Out: Front Desk Initials:
EMPLOYEE NAME: MOAT, BRIAN J HOME	E #:	
DATE OF BIRTH: 06/13/68 SS #:	DEPARTMENT: FIRE/EMS BUREAU	CLAIM # C503-19-63746 -01
DATE OF INJURY: 12/12/19 TIME OF INJUR	RY: INITIAL/RECHECK (PLI	EASE CIRCLE)
TREATING PHYSICIAN: Dr. Apronson	HOW WAS AUTHORIZATION	OBTAINED? THROUGH ASC
DESCRIPTION OF INJURY: LEFT HIP AND	D BACK	
ASSESSMENT/DIAGNOSIS: X 3-44 H	ERNIATED DISC	,
ls condition claimed and compatible to be wo Are known pre-existing or other conditions co		
TREATMENT RENDERED: FVAM		
MEDICATIONS: (prescribed) HYDEO (HE DE	ONE, FLEXERIL, GAMARENTI	'N
	RETURN TO WORK OUTLINE	A THE STATE OF THE
RETURN TO REGULAR DUTY	UPPER EXTREMITY _No use of injured hand/arm	BACKSitting job only
DISCHARGED FROM CARE	No repetitive overhead work	Alternate sit/stand
SENT HOME (UNABLE TO WORK)	No lift/push/pull over lbs. _No repetitive/heavy gripping	May stand/walk up to hrs/dayNo repetitive stoop/bend/twist
ADMITTED TO:	No use of vibrating tools No repetitive/outstretched arm use	May stoop/bend/twisttimes/hourlbs.
LIMITED DUTY IF LIMITED DUTY NOT AVAILABLE, MUST BE OFF WORK UNTIL NEXT VISIT	WER EXTREMITY _Sitting job with foot/leg elevatedAlternate sit/stand, may wa short distances _No squatting or kneeling	OTHERKeep dressing clean/dry alkNo drivingNo use of hazardous machineryMedications may cause drowsiness
DATE TO RETURN TO REGULAR DUTY:		Do not take at work.
FOLLOW UP APPT. REQUIRED? YES NO	AFTER SURGERY DATE	:/TIME:
REFERRAL TO SPECIALTY:		(ASC to make referral)
REFERRAL TO PHYSICAL THERAPY:REFERRAL TO DIAGNOSTIC TESTING:		(ASC to make referral) (ASC to make referral)
Patient:	Date: 12/17/19	Physician:

Date: 12/17/19

WHITE: FAX COMPLETED COPY TO ASC AT 615-360-5692 AND THEN RETAIN IN EMPLOYEE'S FILE. GIVE EMPLOYEE COPY TO RETURN TO SUPERVISOR.



		ity (IOD) ReportMedical Record #:	Date:Time Out: Front Desk	>
EMPLOYEE NAME:	Brian most	HOME #:_ 6\5-	582-2615 WORK	
DATE OF BIRTH:	US SS DEPARTMENT:			
DATE OF INJURY:_	12/12/2019	_TIME OF INJURY:	INITIAL/RECHEC	K (PLEASE CIRCLE)
TREATING PHYSIC OBTAINED?	IAN: Dr Organ a conso	how was authorization	on through Asc	
DESCRIPTION OF INJURY:	Left hip + back			
ASSESSMENT/DIAC	gnosis: No Char	yc		
Are known pre-exis TREATMENT RENDERED:	rgryon	contributing? Yes (No)		
MEDICATIONS: (dispensed/p	prescribed)n	1000 5, gasapenin	, gusuit	
DISCHARGED SENT HOME (L ADMITTED TO: LIMITED DUTY IF LIMITED DUT MUST BE OFF	JNABLE TO WORK)	RETURN TO WORK OUTL UPPER EXTREMITY No use of injured hand/arm No repetitive overhead work No lift/push/pull over lbs. No repetitive/heavy gripping No use of vibrating tools No repetitive/outstretched arm u OWER EXTREMITY Sitting job with foot/leg elevatedAlternate sit/stand, may short distances No squatting or kneeling	BACKSitting job onlyAlternate sit/standMay stand/walk up toNo repetitive stoop/bend/twistMay stoop/bend/twist _seWeight limitlb OTHERKeep dressing clean/d	times/hour os. lry machinery e drowsiness
FOLLOW UP APPT.		D AS NEEDED	DATE: 1 / 30 / 10 T	IME: (ASC to

make referral)

make referral)

CaSes21:21/40090807 DiDoumeent23:122 Scanned: 01/03/2020

REFERRAL TO PHYSICAL THERAPY:

Filed 05/05/23 Plagge55061.44PlaggeDD##84025

(ASC to



Injury On Duty (IOD) Report

	Facility: HOLDERL 1	ALLEO_Medical Record #:	Time Out: Front Desk Initials:	
EMPLOYEE NAME:	BRIAN MOAT	HOME #: <u>6/5-582-26</u>	/5" WORK #:	
DATE OF BIRTH: 6/	3/48 SS#	:DEPARTMENT:	EIRE	
DATE OF INJURY:	2/12/19	TIME OF INJURY:	INITIAL/RECHECK (PLEASE CIRCLE)	
TREATING PHYSICIAL	N: De AAROOSOU	HOW WAS AUTHORIZATION OBTAIN	NED? THROUGH ASC	
DESCRIPTION OF INJ	URY:			
ASSESSMENT/DIAGN	IOSIS: 5/P LUMBA			
Are known pre-exist	ting or other condition	be work related? #Yes No ns contributing? Yes #No 08880 AEO		
MEDICATIONS: (disp	ensed/prescril	bed)		
RETURN TO REGU		RETURN TO WORK OUTLINE UPPER EXTREMITYNo use of injured hand/armNo repetitive overhead work	BACKSitting job onlyAlternate sit/stand	
SENT HOME (UN		No lift/push/pull over lbsNo repetitive/heavy grippingNo use of vibrating toolsNo repetitive/outstretched arm use	May stand/walk up to hrs/day No repetitive stoop/bend/twist May stoop/bend/twisttimes/hour	
LIMITED DUTY	NOT AVAILABLE, DRK UNTIL NEXT VISIT	LOWER EXTREMITY Sitting job with foot/leg elevated Alternate sit/stand, may walk short distancesNo squatting or kneeling	OTHER Keep dressing clean/dry No driving No use of hazardous machinery Medications may cause drowsiness Do not take at work.	
FOLLOW UP APPT. RE REFERRAL TO SPECIA REFERRAL TO PHYSIC REFERRAL TO DIAGN	CAL THERAPY: 2	TIMES TISTIFECCIA WEEK FOR 6	DATE:/TIME:(ASC to make referral) (ASC to make referral) (ASC to make referral)	
I understand this repo	rt and acknowledge rec	celpt of a copy:	- 2 ~	
Patient:		Date:/30/20	Physician:	

Date: 1/30/20

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Date	4/21/20

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		185	

Injury On Du	ty (IOD) Report	Time Out:
Facility: Howers	Ause Medical Record #:	Front Desk Initials:
EMPLOYEE NAME: BRIEN MOR	T HOME #: 415-5-82-2613	6WORK #:
DATE OF BIRTH: 6/13/48	Emp ID#:DEPARTMENT:	FIRE
DATE OF INJURY: 12/12/19	TIME OF INJURY:	INITIAL/RECHECK (PLEASE CIRCLE)
REATING PHYSICIAN: Dr. AAROUS	HOW WAS AUTHORIZATION OBTAIN	NED? THEOUGH POSC
DESCRIPTION OF INJURY:		
ASSESSMENT/DIAGNOSIS: 5/e	PARP DISCECTOMY	
s condition claimed and compatible Are known pre-existing or other cond TREATMENT RENDERED:		
	Page 1 to the control of the control	
MEDICATIONS: (dispensed/pre		
	RETURN TO WORK OUTLINE	
	REIORN TO WORK OUTLINE	
	No use of injured hand/arm No repetitive overhead work	Sitting job only Alternate sit/standmins/hr
/	No lift/push/pull overlbsNo repetitive/tight gripping	May stand/walk up to hrs/dayNo repetitive stoop/bend/twist
ADMITTED TO:	No use of vibrating toolsNo repetitive/outstretched arm/hand usSitting job with foot/leg elevated	May stoop/bend/twist times/hour eWeight limitlbsSit% of the time
LIMITED DUTY IF LIMITED DUTY NOT AVAILABLE,	Stand/walk% of time Alternate sit/stand, may walk short disto	
MUST BE OFF WORK UNTIL NEXT VISIT	No use of hazardous machinery No squatting or kneeling No running/jumping	No driving company vehicles/bus No working heights/on ladders No safety sensitive duties
	Use brace/ walker/ orthotic/ cane/ cr	utches as needed (Please Circle)
FOLLOW UP APPT. REQUIRED?>\textit{Z} YES \textit{\textit{Z}}		DATE:/TIME:(ASC to make referral)
REFERRAL TO PHYSICAL THERAPY:		(ASC to make referral)
REFERRAL TO DIAGNOSTIC TESTING:		(ASC to make referral)
understand this report and acknowledge	receipt of a copy:	AMI
Patient:	Date: 4/21/20	Physician:
		2/9

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GIVE EMPLOYEE COPY TO RETURN TO SUPERVISOR.



Injury On Duty (IOD) Report

Time	In:	

Time Out:	
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Facility: Howell	PALEU Medical Record #:	Front Desk Initials:
		WORK #:
DATE OF BIRTH: 6/13/68	Emp ID#:DEPARTMENT:	FIRE
DATE OF INJURY: 12/12/19	TIME OF INJURY:	INITIAL/RECHECK (PLEASE CIRCLE)
TREATING PHYSICIAN: DE AAROO.	HOW WAS AUTHORIZATION OBTAIN	NED? THROUGH ASC
DESCRIPTION OF INJURY:		
ASSESSMENT/DIAGNOSIS: 3 /3 /24/		
Is condition claimed and compatible Are known pre-existing or other contined the co	e to be work related?—∃Yes □ No ditions contributing? □ Yes ∃No	
MEDICATIONS: (dispensed/pre	escribed) NONE	
	RETURN TO WORK OUTLINE	
RETURN TO REGULAR DUTYDISCHARGED FROM CARESENT HOME (UNABLE TO WORK)ADMITTED TO: LIMITED DUTY IF LIMITED DUTY NOT AVAILABLE, MUST BE OFF WORK UNTIL NEXT VISIT A 5 OF 6/19/20	No use of injured hand/arm No repetitive overhead work No lift/push/pull over27lbs. No repetitive/tight gripping No use of vibrating tools No repetitive/outstretched arm/hand us Sitting job with foot/leg elevated Stand/walk% of time Alternate sit/stand, may walk short distance of hazardous machinery No squatting or kneeling No running/jumping Use brace/ walker/ orthotic/ cane/ cr	Sit% of the time ancesKeep dressing clean/dryNo driving company vehicles/busNo working heights/on laddersNo safety sensitive duties
REFERRAL TO PHYSICAL THERAPY:		DATE://TIME:(ASC to make referral)(ASC to make referral)(ASC to make referral)
I understand this report and acknowledg		101
Patient:	Date:	Physician:



Injury On Duty (IOD) Report

Date	8/18/20	

Time	In:	

Time Out:	

Facility: Howerk	ALLES) Medical Record #:	Front Desk Initials:
FMPLOYEE NAME: Reveal Most	HOME #: //T-1782- 20	2.15 WORK #:
		NT: FIRE
DATE OF INJURY: 12/12/19	TIME OF INJURY:	INITIAL/RECHECK (PLEASE CIRCLE)
TREATING PHYSICIAN: DE AARONS	HOW WAS AUTHORIZATION OBTA	AINED? THROUGH ASC
DESCRIPTION OF INJURY:		
ASSESSMENT/DIAGNOSIS: 5/p Lun	MBAR NISCECTOMY	
Is condition claimed and compatible Are known pre-existing or other con TREATMENT RENDERED: EXAM	ditions contributing? Yes- No	
MEDICATIONS: (dispensed/pre	escribed)	IE .
	KETOKN TO WORK OUTLIN	
RETURN TO REGULAR DUTYDISCHARGED FROM CARESENT HOME (UNABLE TO WORK)ADMITTED TO: LIMITED DUTY IF LIMITED DUTY NOT AVAILABLE, MUST BE OFF WORK UNTIL NEXT VISIT	No use of injured hand/arm No repetitive overhead work No lift/push/pull over 25 lbs. No repetitive/tight gripping No use of vibrating tools No repetitive/outstretched arm/hand Sitting job with foot/leg elevated Stand/walk% of time Alternate sit/stand, may walk short of No use of hazardous machinery No squatting or kneeling No running/jumping	Sit% of the time
FOLLOW UP APPT. REQUIRED? TYES	Use brace/ walker/ orthotic/ cane/	crutches as needed (Please Circle) DATE:/
REFERRAL TO SPECIALTY:	confine or	(ASC to make referral) (ASC to make referral) (ASC to make referral)
I understand this report and acknowled	111	180
Patient:	Date: 8/18/20	Physician:

WHITE: FAX COMPLETED COPY TO ASC AT 615-360-5692 AND THEN RETAIN IN EMPLOYEE'S FILE.



Form - 201 Injury On Duty (IOD) Report

Date:	1-8-20	
Time In:	1045	
Time Out:_	· 12P	
Front Desk	Inilials: 'CP_	

Facility: Metro IOD Clinic		Front Desk Inilials: CP_
Moat, Brian J.	HOME #:	
Employer: Metro IOD Clinic-ONSITE ONLY SSN: DOB: 06/13/1968 Case Date: 12/12/2019	TAE	IITIAL (RECHECK (PLEASE ÇIRCLE)
ASSESSMENT/DIAGNOSIS:	contributing? \square Yes \square No	TAINED? ASC moders placed male on
TREATMENT RENDERED: Oxam,	viay, critiches	
MEDICATIONS: (prescribed)		
RETURN TO REGULAR DUTY DISCHARGED FROM CARE SENT HOME (UNABLE TO WORK) ADMITTED TO: LIMITED DUTY IF LIMITED DUTY NOT AVAILABLE MUST BE BE OFF WORK UNTIL NEXT VISIT Additional notes: STAR TS 1.	No lift/push/pull over lbsNo repetitive/heavy grippingNo use of vibrating toolsNo repetitive/outstretched arm use LOWER EXTREMITY	No use of hazardous machineryMust wear brace as directedMedications may cause drowsiness
DATE TO RETURN TO REGULAR DUTY: FOLLOW UP APPT. REQUIRED? IT YES REFERRAL TO SPECIALTY: REFERRAL TO PHYSICAL THERAPY: REFERRAL TO DIAGNOSTIC TESTING: I understand this report and acknowledge Patient: COMPLETED COPY WAS FAXED TO ASC AT	DATE:	TIME: cdule, call 615-880-2400 (ASC to make referral) (ASC to make referral) (ASC to make referral) estimate: ETAIN COPY IN EMPLOYEE'S FILE.

Scanned: 09/08/2020

NORMA TOMI IN



Injury On Duty (IOD) Report

Facili	ity: UUMC	Medical Record #:		ont Desk Initials:
1		DAY HOME #: 615. SY2. Z	1	
	•		west pringer	IAL/RECHECK (PLEASE CIRCLE)
TREATING PHYSICIAN: 6	444GHV12	_HOW WAS AUTHORIZATION OBTAIN	NED?	ASC
DESCRIPTION OF INJURY:_	(Poste	nor Tibred Tala	_ ~	
No.		in Toul Tal	~ \	8-1
Is condition claimed and of Are known pre-existing or TREATMENT RENDERED:	other conditions co			
Pahenl	can re	two to full unrest	nch	ed PT
MEDICATIONS: (dispensed	/prescribed_))		
RETURN TO REGULAR D		RETURN TO WORK OUTLINE ER EXTREMITY No use of injured hand/arm	BAC	K Sitting job only
DISCHARGED FROM CA	ARE	No repetitive overhead work No lift/push/pull over lbs.		Alternate sit/stand May stand/walk up to hrs/day
ADMITTED TO:		No repetitive/heavy gripping No use of vibrating tools No repetitive/outstretched arm use		No repetitive stoop/bend/twist May stoop/bend/twisttimes/hour Neight limitlbs.
LIMITED DUTY IF LIMITED DUTY NOT A MUST BE OFF WORK UN	VAILABLE, TIL NEXT VISIT	VER EXTREMITY Sitting job with foot/leg elevated Alternate sit/stand, may walk short distances No squatting or kneeling	_	R Keep dressing clean/dry No driving No use of hazardous machinery Medications may cause drowsiness
DATE TO RETURN TO REGULA				Do not take at work.
FOLLOW UP APPT. REQUIRED REFERRAL TO SPECIALTY:	D? (YES) NO	• AS NEEDED	DATE	after mel :
REFERRAL TO PHYSICAL THE REFERRAL TO DIAGNOSTIC		21 (L) Whe		(ASC to make referral)
I understand this report and a	cknowledge receipt o	of a copy:		

Patient:	Fru AM	Date:9 22 20	Physicign:

WHITE: FAX COMPLETED COPY TO ASC AT 615-360-5692 AND THEN RETAIN IN EMPLOYEE'S FILE. GIVE EMPLOYEE COPY TO RETURN TO SUPERVISOR.



Injury On Duty (IOD) Report

	Facility: HOWELL ALLEN	Medical Record #: Calul c	Front Desk Initials:
EMPLOYEE NAME: _/	BRIAN MOAT	HOME #: 615-3782-261	/5_WORK #:
DATE OF BIRTH: 6/	13/68 SS #	EDEPARTMENT:	(RE
DATE OF INJURY:_/	2/12/19	TIME OF INJURY:	INITIAL RECHECK (PLEASE CIRCLE)
TREATING PHYSICIA	N: DR. AARON SO	HOW WAS AUTHORIZATION OBTAIN	NED? THROUGH 193C
DESCRIPTION OF IN.	JURY:		
ASSESSMENT/DIAGN	NOSIS: 5/p rami		
	ting or other condition	be work related? — Yes 🗆 No ons contributing? 🗆 Yes — No	
MEDICATIONS: (disp	pensed/prescri	ibed) 116128	
RETURN TO REG	ULAR DUTY	RETURN TO WORK OUTLINE UPPER EXTREMITY	BACK Sitting ich call
DISCHARGED F	ROM CARE	No use of injured hand/armNo repetitive overhead work	Sitting job onlyAlternate sit/stand
SENT HOME (UN	IABLE TO WORK)	No lift/push/pull over 25 lbs. No repetitive/heavy gripping	May stand/walk up to hrs/dayNo repetitive stoop/bend/twisttimes/hour
ADMITTED TO:_		No use of vibrating tools No repetitive/outstretched arm use	
	NOT AVAILABLE, ORK UNTIL NEXT VISIT	LOWER EXTREMITYSitting job with foot/leg elevatedAlternate sit/stand, may walk short distances	OTHERKeep dressing clean/dryNo drivingNo use of hazardous machinery
DATE TO RETURN TO	REGULAR DUTY:	No squatting or kneeling	Medications may cause drowsiness Do not take at work.
FOLLOW UP APPT. R REFERRAL TO SPECIA REFERRAL TO PHYSIC REFERRAL TO DIAGN	CAL THERAPY: WO		DATE:/TIME:(ASC to make referral) (ASC to make referral) (ASC to make referral)
I understand this repo	t and acknowledge ve	Date: 11/24/20	Physician:

WHITE: FAX COMPLETED COPY TO ASC AT 615-360-5692 AND THEN RETAIN IN EMPLOYEE'S FILE. GIVE EMPLOYEE COPY TO RETURN TO SUPERVISOR.

Date: 11/24/20



DESCRIPTION OF INJURY:

TREATMENT RENDERED: EXAM

Injury On Duty (IOD) Report

DATE OF BIRTH: 6/13/68 Emp ID#:

DATE OF INJURY: /2/12/19 TIME OF INJURY:

ASSESSMENT/DIAGNOSIS: 5/P LUMBAR DISCECTOMY

MEDICATIONS: (dispensed____/prescribed____) NONE

Is condition claimed and compatible to be work related? — Yes \(\Bar{\text{No}} \) Are known pre-existing or other conditions contributing? ☐ Yes-☐-No

EMPLOYEE NAME: BEIAN MOAT HOME #: 6/5- 582- 26/5 WORK #:

TREATING PHYSICIAN: Dr. AARONSON HOW WAS AUTHORIZATION OBTAINED? THROUGH

	Date 3/9/21
	Time In:
Injury On Duty (IOD) Report	Time Out:
Facility: Howers Arrest Medical Record #: Front Desk Initials	
BRIAN MOAT HOME #: 6/5- 582- 24/5 WORK #: 12/13/48 Emp ID#: DEPARTMENT: FIRE 12/12/19 TIME OF INJURY: INITIAL RECHECK	
AN: Dr. AARONSON HOW WAS AUTHORIZATION OBTAINED? THROUGH	
NJURY:	
ed and compatible to be work related?——Yes No Kisting or other conditions contributing? Yes——No KED: EXAM	

_(ASC to make referral)

_(ASC to make referral)

	RETURN TO WORK OUTLINE	
RETURN TO REGULAR DUTY		
DISCHARGED FROM CARE	No use of injured hand/arm No repetitive overhead work	Sitting job only Alternate sit/standmins/hr
SENT HOME (UNABLE TO WORK)	No lift/push/pull overlbsNo repetitive/tight gripping	May stand/walk up to hrs/dayNo repetitive stoop/bend/twist
ADMITTED TO:	No use of vibrating toolsNo repetitive/outstretched arm/hand use	May stoop/bend/twist times/hour Weight limitIbs.
LIMITED DUTY	Sitting job with foot/leg elevated Stand/walk% of time	Sit% of the time
IF LIMITED DUTY NOT AVAILABLE, MUST BE OFF WORK UNTIL NEXT VISIT	Alternate sit/stand, may walk short distanc No use of hazardous machinery	esKeep dressing clean/dry No driving company vehicles/bus
	No squatting or kneeling No running/jumping	No working heights/on ladders No safety sensitive duties
	Use brace/walker/ orthotic/ cane/ crute	has as needed (Please Circle)

AS NEEDED

REFERRAL TO PHYSICAL THERAPY: WORK HARDENING 2 TIMES PER WEEK FOR 8 WEEKS (ASC to make referral)

Date: 3/9/2/

WHITE: FAX COMPLETED COPY TO ASC AT 615-360-5692 AND THEN RETAIN IN EMPLOYEE'S FILE.

GIVE EMPLOYEE COPY TO RETURN TO SUPERVISOR.

I understand this report and acknowledge receipt of a copy:

FOLLOW UP APPT. REQUIRED? | YES | NO

REFERRAL TO DIAGNOSTIC TESTING:

REFERRAL TO SPECIALTY:

Patient: